

VULVOVAGINAL CANDIDIASIS

I. INTRODUCTION

Vulvovaginal candidiasis is a fungal infection of the vagina and/or vulvar/perineal area that accounts for approximately one-third of cases of vaginitis. The most frequent cause of candida vulvovaginitis is candida albicans. The usual clinical picture is that of itching, burning and erythema. Vulvovaginal candidiasis is not considered a sexually transmitted disease.

II. HISTORY AND PHYSICAL EVALUATION

- A. History may include:
 - 1. Recent antibiotic use
 - 2. Corticosteroid use
 - 3. Diabetes/hyperglycemia
 - 4. Pregnancy
 - 5. Immunosuppressive disorders
- B. Symptoms may include:
 - 1. Vulvovaginal pruritis
 - 2. White, odorless discharge
 - 3. Dysuria
 - 4. Dyspareunia
- C. Physical exam findings may include:
 - 1. Erythema of the vulva and vaginal mucosa
 - 2. Vulvar edema
 - 3. Thick, adherent, and "cottage cheese-like" discharge (although may be thin and loose discharge as well)
 - 4. Evidence of excoriation and fissures

III. DIAGNOSIS

Diagnosis is usually made by direct microscopic visualization of hyphae or spores (10% KOH wet prep). A negative KOH test, however, does not exclude the diagnosis. Candida found on a Pap smear may represent an asymptomatic carrier not necessarily needing treatment.

IV. PLAN

Provide treatment if client has above signs or symptoms following the most recent CDC STD Treatment Guidelines found at:
<https://www.cdc.gov/std/tg2015/candidiasis.htm>

V. SPECIAL TREATMENT CONSIDERATIONS

Certain antifungal drugs interact with other medications. Miconazole and warfarin can lead to bleeding or bruising. Fluconazole may interact with coumarin-type anticoagulants, cyclosporine, oral hypoglycemics, phenytoin, rifabutin, rifampin, tacrolimus, theophylline, and COX-2 inhibitors (Celebrex®).

VI. CLIENT EDUCATION/COUNSELING

- A. Many of the OTC vaginal preparations also have in the packaging a tube of the same ingredient for external vulvar use.
- B. Latex barrier devices, including latex condoms and diaphragms, may break down when in contact with oil-based vaginal medications, such as miconazole, clotrimazole, terconazole, tioconazole, and butoconazole.
- C. When there is vulvar inflammation, the use of an antifungal cream with or without a corticosteroid (such as hydrocortisone cream 0.5-1.0%, OTC) will reduce symptoms more readily.
- D. Routine treatment of sex partners is usually unnecessary since this infection is not acquired through sexual intercourse.

VII. FOLLOW-UP

Clients should return for follow-up visits if symptoms persist or recur. Women with frequent or persistent infections should be evaluated for risk factors and be treated with the 7-day therapies. Multiple treatments and/or maintenance regimens may be required.

REFERENCES

CDC, Sexually Transmitted Diseases Treatment Guidelines. 2015